COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

July 31, 2015

To: Los Angeles County Commission for Children and Families

From: Department of Mental Health

SUBJECT: REPORT ON PSYCHOSOCIAL INTERVENTIONS FOR YOUTH IN FOSTER CARE

INTRODUCTION

On April 20, 2015 there was a presentation provided to the Commission for Children and Families (the Commission) by Department of Mental Health (DMH) administrators on the pharmacological treatments provided to youth in care. Additional questions resulted from this initial presentation. Specifically, the Commission requested data concerning non-pharmacological treatments provided to children/youth in care, with specific questions raised as listed below:

1. What is the nature of the psychosocial interventions that children in care are receiving (treatment models, individual/group modalities, length of treatment, and frequency of visits)?
2. Number of children receiving psychosocial (non-pharmacological) treatments
3. Treatment models by diagnoses
4. Treatment models by age and ethnicity
5. Frequencies of cases in which medication and psychosocial treatments are provided
6. Geographic distribution of psychosocial treatments (do they vary by SPA, for example)
7. One further question related to psychotropic medication is whether there are reports on the diagnosis for which each medication, particularly the anti-psychotic medications, is prescribed. In the very helpful data runs that we received at the meeting, frequencies are provided for each diagnosis and for each medication, but they are not connected. Is it possible to run a report that shows the relationship between prescription and diagnosis?

The analysis which follows is an attempt to answer these questions. It includes a review of the non-pharmacological treatment modalities and other programs Katie A. class members received during fiscal year 2013-2014. Katie A. class members are children/youth with open Department of Children & Family Services (DCFS) cases, who are eligible for Early Periodic Diagnosis and Treatment (EPSDT) services and who meet the medical necessity threshold for the receipt of such services. It is important to note that this data does not pertain to all youth in foster care but only those, almost 26,000 that received mental health services through the Department of Mental Health (DMH) and services that were billed to Medi-Cal. Within this analysis is a closer look at some of the most common programs/interventions Katie A. class members received. The data has been divided into six programs/interventions children/youth, totaling more than 13,000, received through DMH. These formal programs/interventions include Field Capable Clinical Services (FCCS), Treatment Foster Care (TFC), Full Service Partnership (FSP), Wraparound, Intensive Field Capable Clinical Services (IFCCS) and youth that received Evidence-Based Practices (EBPs). It is important to note that some of the children/youth may have been enrolled in multiple programs above within this time period. For this analysis, we have identified children/youth that received medication support services as receiving psychotropic medication; however this is an approximation. In some instances, a child/youth may receive medication support services but not receive psychotropic medication (i.e., child/youth is referred for a medication evaluation but the psychiatrist determines the child/youth does not need psychotropic medication). Below is a description of each of the programs/interventions listed above.

Children's Field Capable Clinical Services (FCCS) are specialty mental health services for children ages birth to 15 and their families who may want services outside of traditional mental health settings. Services are delivered in a variety of settings including schools, health centers and community centers. The program focuses on children who may have: 1) Experienced trauma; 2) School failures; 3) A suicide risk; 4) Foster care or juvenile justice involvements; 5) A history of psychiatric hospitalizations or are at risk for psychiatric hospitalization; or 6) A diagnosed co-occurring substance abuse, developmental or medical disorder. The average length of stay in the program is 8 months and children receive face-to-face services at least one time per week.

Treatment Foster Care (TFC) was created as an alternative to group facilities and is a joint program between DCFS and DMH. The program places DCFS foster children in specialized resource homes where trained resource parents are matched to the specific needs of each youth. The result is an individualized treatment program for the youth that is supported 24/7.The average length of stay in this program is 14 months and children/youth receive face-to-face services at least two times per week.

Full Service Partnership (FSP) program is a unique intensive in-home mental health service program. FSP providers work with children/youth and their families to assist them plan and accomplish goals that are important to the health, well-being, safety and stability of the family. Services may include but are not limited to individual and family counseling, 24/7 assessment and crisis services, and substance abuse and domestic violence

counseling and assistance. Services are provided in the language of the families' choice. The average length of stay is 15 months and children/youth receive face-to-face services one to two times per week.

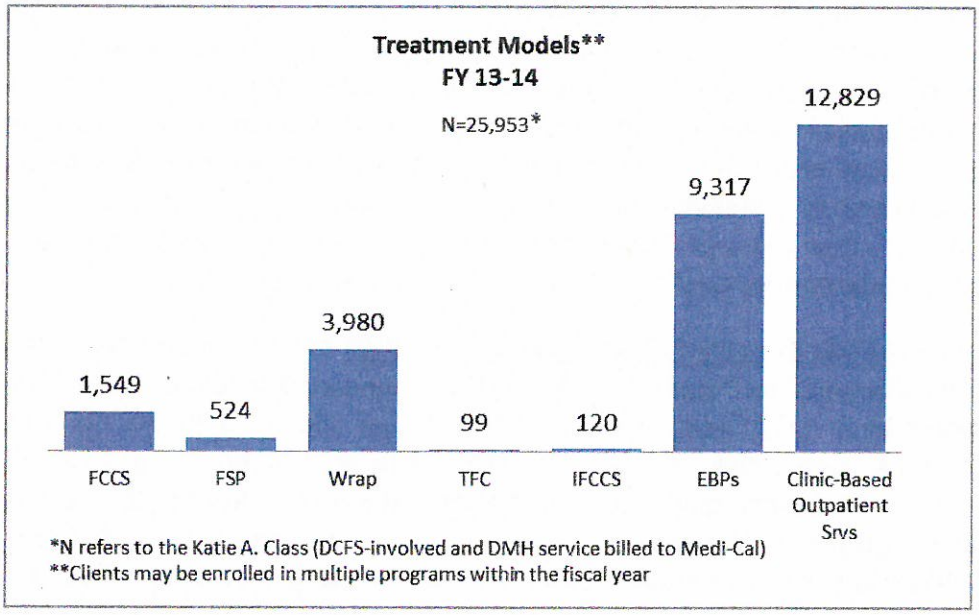
Wraparound is a child–focused, family-centered, strengths-based, needs-driven planning process. Wraparound also provides access to an array of comprehensive mental health services. Service delivery objectives are to assist children/youth in returning home and successfully remaining home; preventing future disruption or placements, symptom reduction as well as overall improvement of family functioning and preventing psychiatric hospitalization. Wraparound supports family voice, choice and ownership of strategies to return or maintain youth in their community with normalized and inclusive community options, activities and opportunities (i.e., services provided in the most homelike setting). Wraparound includes a commitment to create and provide a highly individualized planning process and to persevere until the desirable outcomes for the children and families are achieved. The average length of stay in the program is 15 months and children/youth receive face-to-face services at least two times per week.

Intensive Field Capable Clinical Services (IFCCS) are an array of services firmly grounded in the Shared Core Practice Model and are intended to expedite access to Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) for Katie A. subclass members. Specifically, IFCCS are targeted to youth who are in one of our "Hot Spot" locations 1) Discharging from the Exodus Recovery Urgent Care Centers (UCCs); 2) Discharging from Psychiatric Hospitalizations; 3) Awaiting placement at the DCFS Children and Youth Welcome Centers or 4) The subject of a joint response from the DMH Field Response Operation Team without a psychiatric hospitalization. These "hot spots" have been targeted as the youth that come into contact with these locations typically need a higher level of service and have difficulty connecting to one of our other intensive programs because of their frequent placement disruptions. The average length of stay is 5 months and children/youth receive face-to-face services two to three times per week.

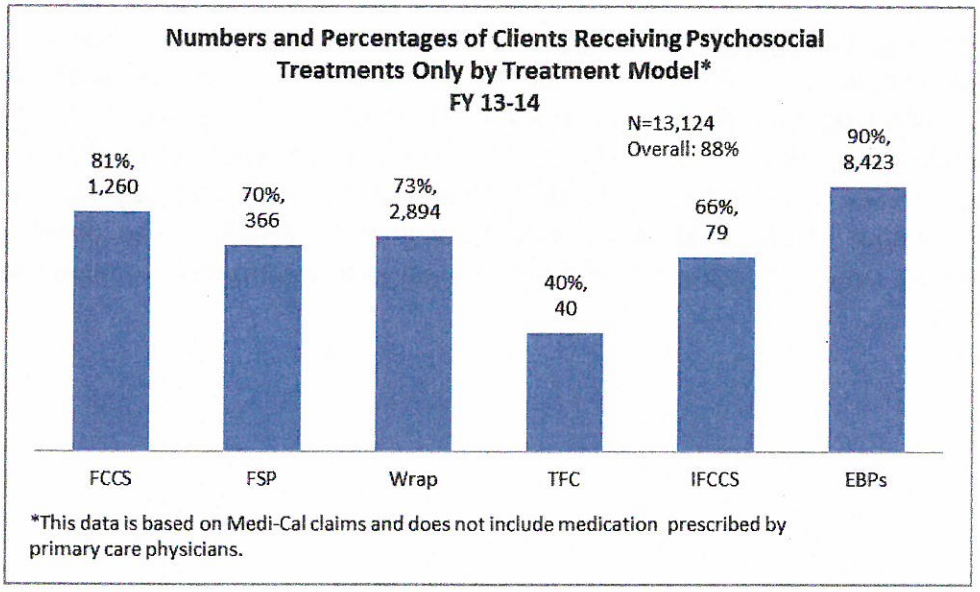
Evidence-Based Practices (EBPs) - There are a large number of Katie A. children/youth that received an EBP and/or Promising Practice, the majority of which received Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) or Managing and Adapting Practice (MAP) during Fiscal Year 2013-2014. The average length of treatment and number of face-to-face visits varies by EPB. These EBP's are funded by Prevention and Early Intervention (PEI) of Mental Health Service Act (MHSA). The other aforementioned services may also include EBP's but they are not systematically tracked as those funded by PEI.

1. *What is the nature of the psychosocial interventions that children in care are receiving (treatment models, individual/group modalities, length of treatment, and frequency of visits)?*

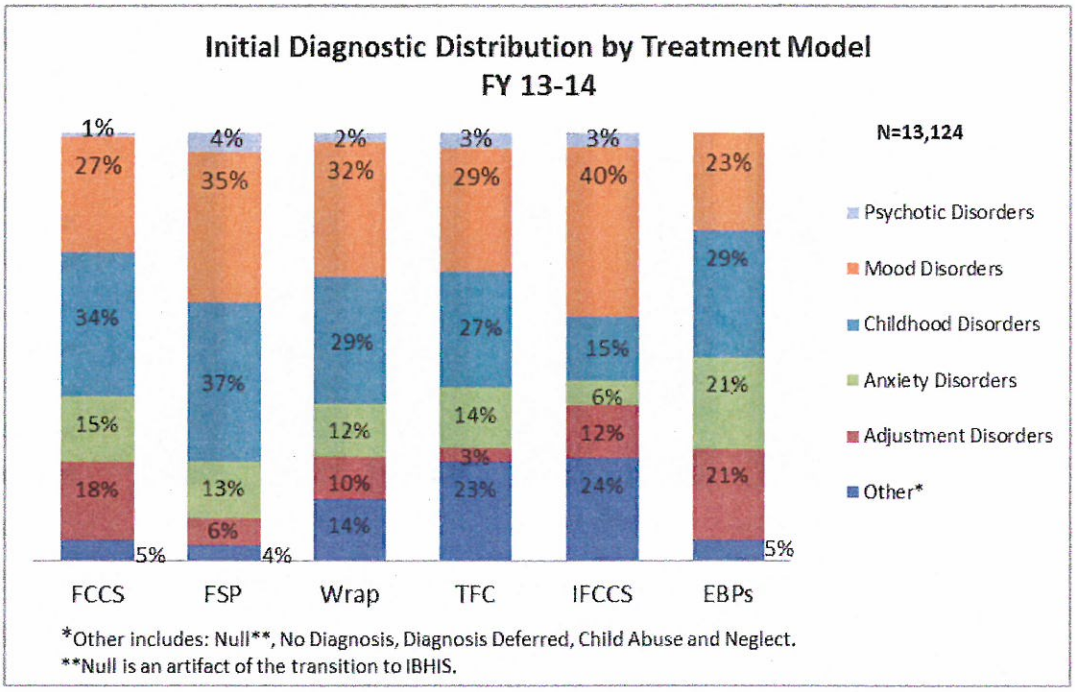
While treatment models are described above, including modalities, standard lengths of treatment and frequency of visits, the distribution of interventions is reflected in the chart below.



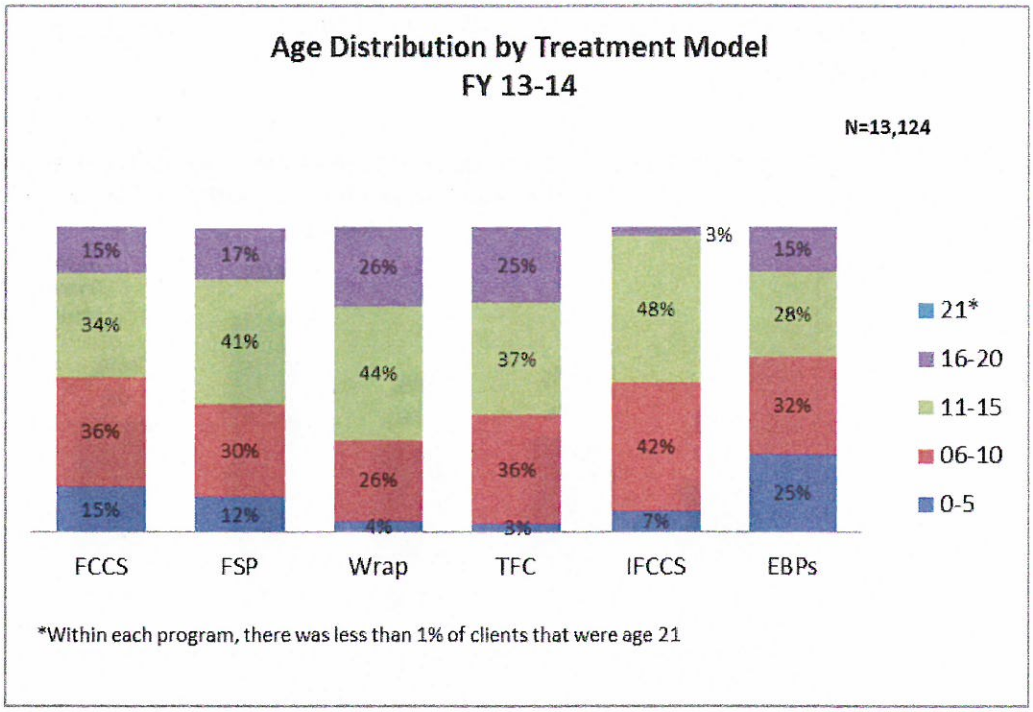
2. *Number of children receiving psychosocial (non-pharmacological) treatments only (no medication)*

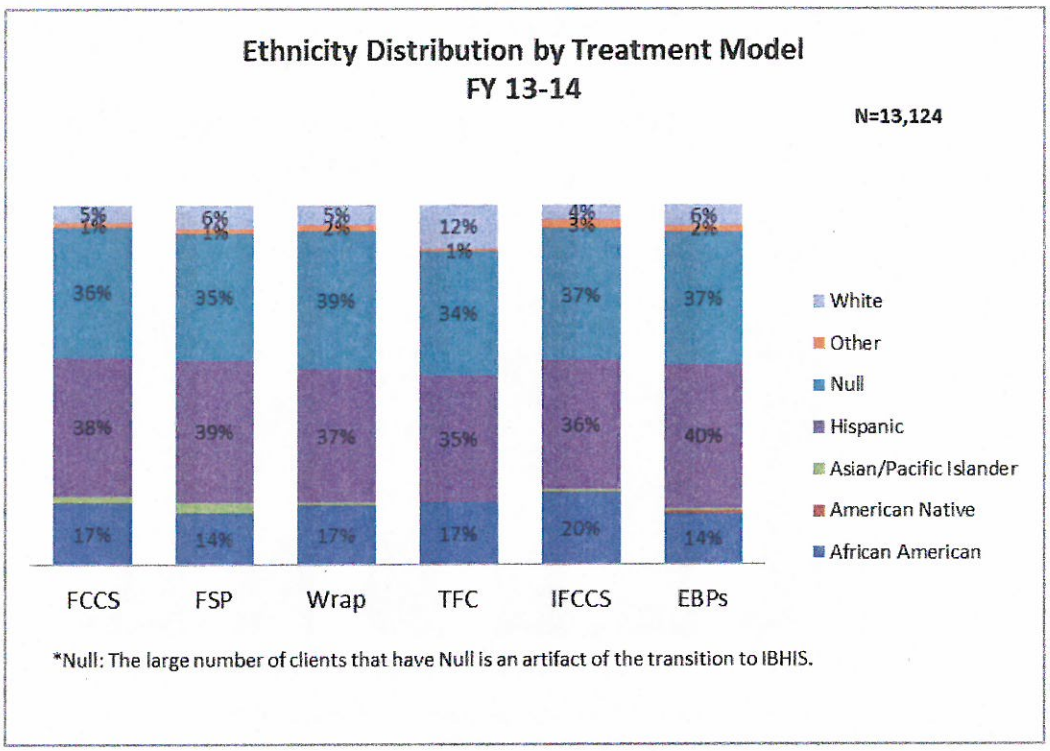


3. *Treatment models by diagnoses*

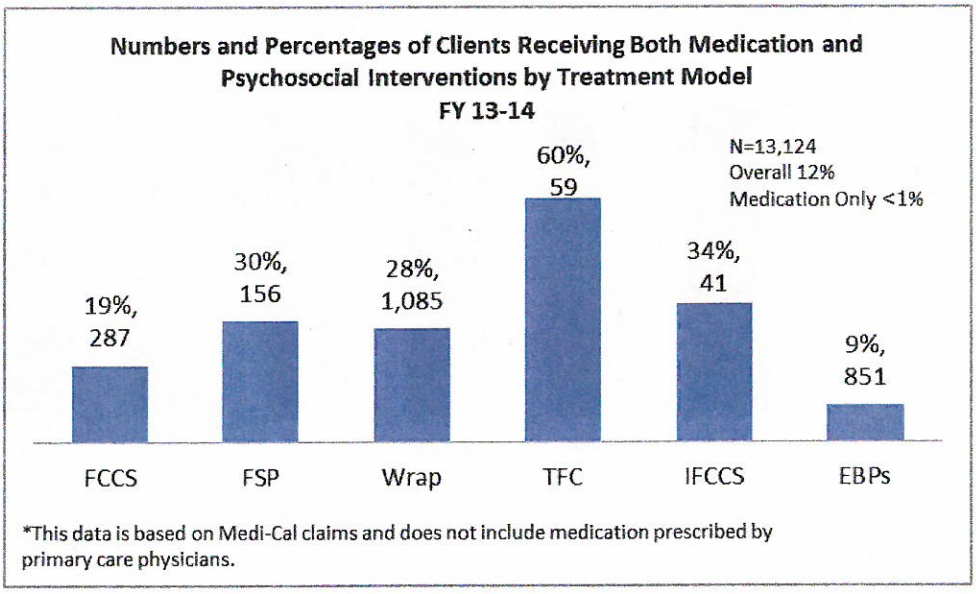


4. *Treatment models by age, ethnicity*

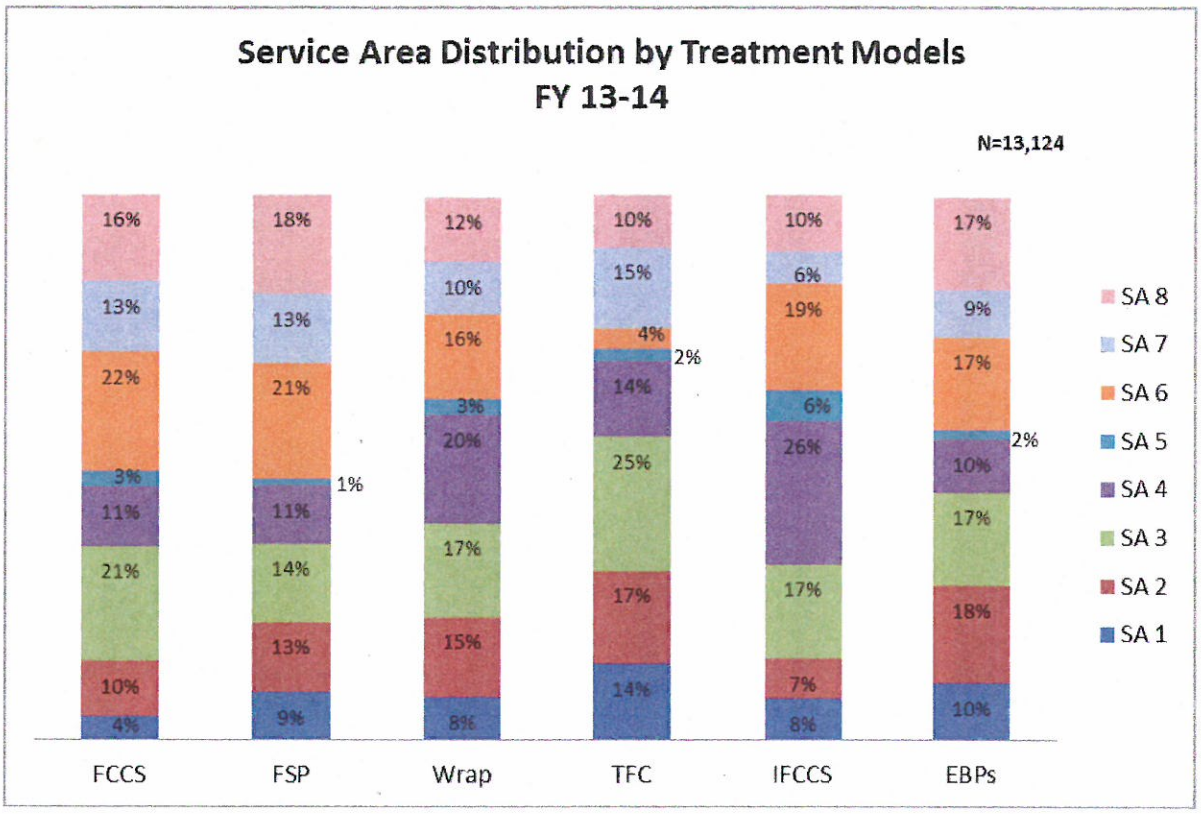




5. *Frequencies of cases in which medication and psychosocial treatments are provided*



6. *Geographic distribution of psychosocial treatments (do they vary by SPA, for example)*



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   We do not have data to answer this question at this time.